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AIHW

Indigenous health check (MBS 715) data tool

Web report

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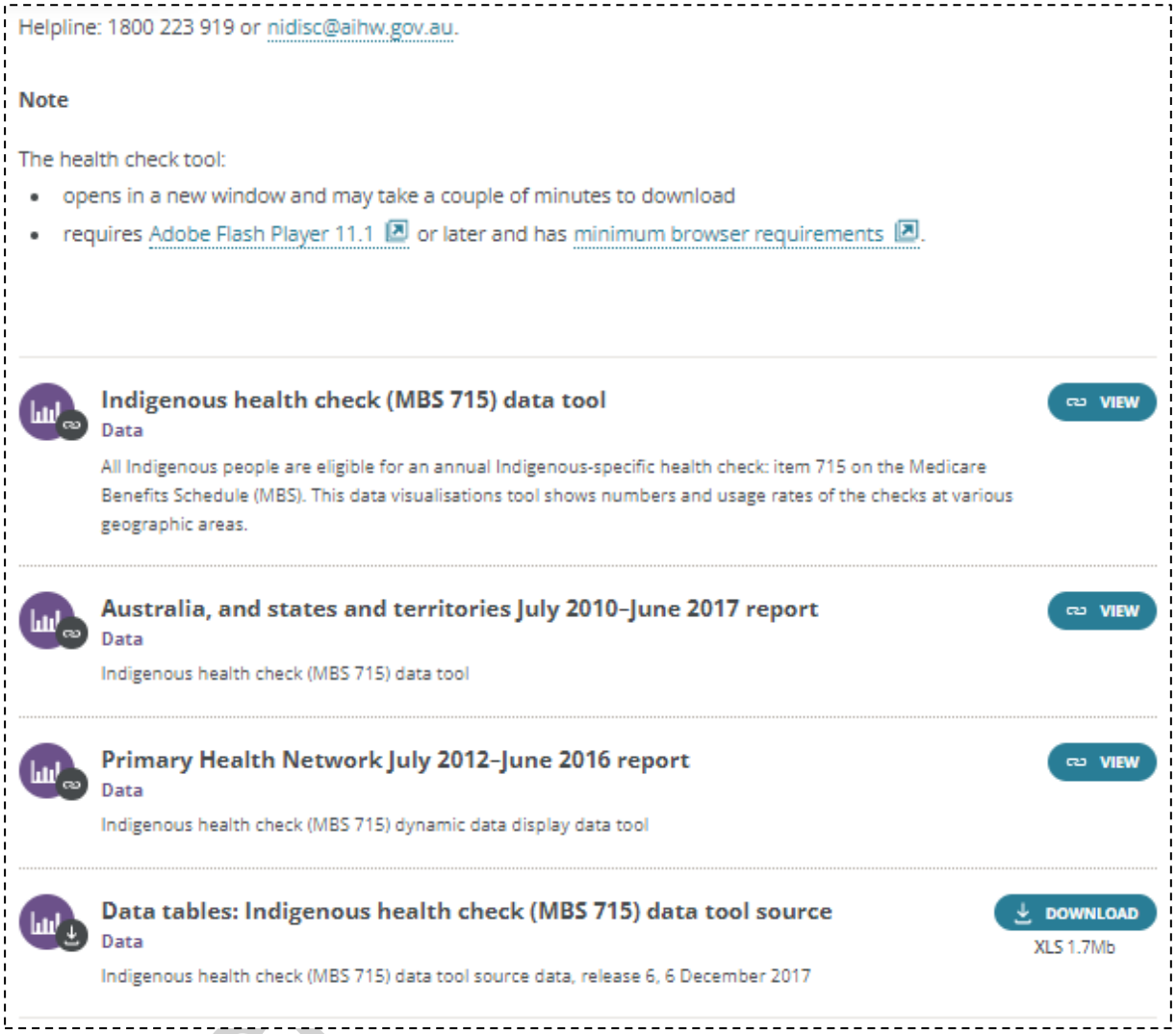
All Indigenous people are eligible for an annual Indigenous-specific health check: item 715 on the Medicare Benefits Schedule (MBS). This tool shows numbers and usage rates of the checks at national, state and territory and Primary Health Network levels. Charts can be customised to show different time periods and, where possible, disaggregations by age and sex.

Key findings:

- Nationally, the health check usage rate increased from 11% in 2010-11 to nearly 29% in 2016–17.
- Nationally, the number of health checks billed each year increased from 71,400 in 2010–11 to 217,700 in 2016–17.
- Health check rates in 2016–17 ranged from 23% (in people aged 15–24) to 43% (in people aged 65 and over).
- Between 2010–11 and 2016–17, health check rates were higher for females than males in all age groups over 15 years.

Data visualisations

Screenshot 1. Content page containing SAS VA links and a download table.



Data information

Age and sex data

Report 1, on national and state and territory data, shows the age group and sex of people who had Indigenous-specific health checks. It uses 8 age groups: 0–4, 5–14, 15–24, 25–34, 35–44, 45–54, 55–64, and 65 and over.

Report 2, on Primary Health Network data, does not include age and sex breakdown as these are not provided in the source data.

Closing the Gap

The Council of Australian Governments' 2008 Closing the Gap reforms included commitments to close the gap in life expectancy between Indigenous and non-Indigenous Australians within a generation (by 2031) and to halve the gap in mortality rates for Indigenous children aged under 5 within a decade (by 2018). Ensuring and increasing access to health checks is an important part of achieving these commitments. This is because the checks can provide both direct health benefits and access to additional Indigenous-specific health measures.

The Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023 sets out the health check goals to be achieved by 2023.

Data sources

Table 1: Data inclusions and sources: Report 1 (National and state and territory data, July 2010–June 2017)

Data inclusions	Data sources
Number of health checks recorded by Medicare	MBS data: Medicare Statistics
Indigenous population	Indigenous population estimates and projections, Series B projections produced by the Australian Bureau of Statistics (ABS), based on 2011 Census counts (with some amendments for Tasmania and the ACT. See Population estimates).
Usage rate	Calculated by dividing number of health checks by the total Indigenous population.

Table 2: Data inclusions and sources: Report 2 (PHN data July 2012 to June 2016)

Data inclusions	Data sources
Number of health checks recorded by Medicare	MBS data by Primary Health Network
Indigenous population	Indigenous population estimates and projections, Series B projections, produced by the Australian Bureau of Statistics (ABS), based on 2011 Census counts
Number of services where GPs work	Collated by the AIHW. See Number of services where GPs work.
Usage rate	Calculated by dividing number of health checks by the relevant Indigenous population

Data suppression

The Department of Human Services occasionally suppresses data for some geographical areas smaller than states and territories to ensure patient and provider confidentiality. There is no data suppression in Report 1: national and state and territory data.

There are 3 instances of data suppression in Report 2: Primary Health Network data. These occurred in financial year 2012/13 in 3 different Primary Health Networks (Central and Eastern Sydney, Western Sydney, and North Western Melbourne). These suppressed data are noted in the related data tables.

Geographic areas

Differences in usage rates across geographic levels should be interpreted with caution because the use of MBS 715 health checks is influenced by a number of factors which may vary by geographic areas, including:

- access to MBS-billing GP services—MBS-billing services are not uniformly available across Australia, with people in remote areas more likely than those in other areas to have a greater reliance on non-MBS GP billing services
- access to other primary health care—Indigenous people may receive regular comprehensive primary health care through other avenues or have established care arrangements, such as a chronic disease management plan
- other regional differences—such as access to any GP services, regardless of whether or not they are MBS-billing services (see Number of services where GPs work).

Health checks: barriers

Although all Aboriginal and Torres Strait Islanders are eligible for a health check, there are a range of reasons why some Indigenous people do not have one. For example:

- Health checks are voluntary for both GPs and Aboriginal and Torres Strait Islander people, and not all Indigenous people or GPs may wish to participate.
- Mainstream general practices may not collect Indigenous status information for all patients (see Indigenous identification). If GPs are not aware of which patients are Indigenous, they cannot offer Indigenous-specific health measures such as the health check.
- There is no requirement for GPs to bulk bill Indigenous people for the health check. Any fees charged to the patient can present a financial barrier for many Indigenous people.
- Health checks may not be needed for Indigenous people receiving regular comprehensive primary health care through other avenues, or for those with an ongoing chronic disease with established care arrangements, such as chronic disease management plans.

Also, health care equivalent to a MBS item 715 health check may be provided but not billed to Medicare for a variety of reasons (see Health checks not billed to the MBS).

Additional provider-level specific barriers to delivering and billing health checks have been investigated in a number of studies. Patient-level factors affecting uptake have also been studied, but to a lesser degree.

In mainstream general practice, a number of provider-level barriers have been identified (Kehoe & Lovett 2008; Schütze et al. 2016), including:

- process and system barriers such as:
  - lack of processes to seek Indigenous status information from all patients
  - prevalence of GP software that does not facilitate recording and use of Indigenous status information, or prompt use of Indigenous-specific measures like the health check
  - real and/or perceived lack of time and workforce resources to undertake health checks
  - avoidance of billing health checks because of perceptions that the process was complicated and/or laborious, and because of fear of a claim being rejected.
- knowledge barriers such as:
  - confusion about definitions of Indigenous status
  - lack of awareness of health checks.
- attitudinal barriers such as views that:
  - Aboriginal and Torres Strait Islander patients are one of many high needs subgroups, and therefore special treatment is unjustified
  - general practices should 'treat all patients the same'

- Indigenous-specific measures are not warranted by clinical evidence.

Barriers to health check uptake have also been identified in Indigenous medical services (Jennings et al. 2014). These include:

- lack of clear clinical systems for conducting health checks, such as uncertainty about staff responsibilities for initiating and conducting the health check
- time pressures for both patients and clinic staff
- perceptions among some staff that aspects of the health check were sensitive, invasive, culturally inappropriate and of questionable value
- concerns about community health literacy, disengagement with preventative health care, and suspicion about confidentiality and privacy.

Strategies to increase uptake of health checks have been described, including by the Menzies School of Health Research (2013). At the individual health service level, these include:

- allocating dedicated time for GPs and other staff to undertake the checks
- changing systems to enable completion of checks over successive visits
- aligning clinical information and other systems to support Medicare billing
- motivating patients to participate in checks.

At the regional level, support agencies, such as the then Medicare Locals, were identified as potentially important in helping complete health checks by providing information and organisational support to maximise revenue and improve service delivery.

Health checks: general

All Aboriginal and Torres Strait Islander people, regardless of age, are eligible for an annual Indigenous-specific health check. This health check, listed as item 715 on the Medicare Benefits Schedule (MBS), was designed especially for Indigenous people. It was established because Indigenous people have considerably higher morbidity and mortality levels than non-Indigenous people, with earlier onset and more severe disease progression for many chronic diseases. The aim of the health checks is to provide Indigenous people with primary health care matched to their needs by supporting early detection, diagnosis and intervention for common and treatable conditions.

Ensuring access to the health check is an important part of the Australian Government's commitments to Closing the Gap in both life expectancy and mortality. Although use of health checks has increased substantially over time, about 70% of the Indigenous population did not have a health check in 2016-17. The AIHW Indigenous health check data tool aims to increase awareness, understanding and uptake of the health check among health care providers and Indigenous people.

The requirements of a health check, which are set out in the relevant section of the MBS, include an assessment of the patient's health, including their physical, psychological and social wellbeing. The check also assesses what preventive health care, education and other help should be offered to the patient to improve their health and wellbeing.

Specific elements for health checks for people of different ages are set out in pro formas for:

- Child health assessments (0–14)
- Adult health assessments (15–54)
- Older person health assessments (55 and over).

As at October 2017, the MBS rebate for a health check was $212.25. If the GP bulk bills this item, there is no charge to the patient. Health checks can be provided by any Medicare-billing GP—including those in mainstream practices and those providing services mainly for Indigenous people—and should generally be provided by the patient's usual doctor.

The outcome of a health check may include access to other Indigenous-specific health measures. For example, if a GP identifies a need for follow-up care during a health check, they can give Indigenous people access to MBS-rebated follow up services from allied health workers, practice nurses and Aboriginal health workers.

For more information on the health check, see the Department of Health.

Data on the number of health checks shown in this tool are the number of checks billed to Medicare in the relevant period, not the number of people who received a health check. That is, available data do not distinguish between a person receiving 2 health checks in one 12-month period and 2 different people receiving a health check in the same period. However, given these health checks are generally provided on an annual basis (although the minimum time allowed between checks is 9 months), the number of checks in a 12-month period is likely to be similar to the number of people receiving the checks.

Health checks: goals

The Indigenous Chronic Disease Package, implemented over 4 years from 2009 to 2013, aimed to increase health check uptake among Indigenous adults from about 10% (the then baseline) to 45%.

The Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023 set new goals for increasing the uptake of Indigenous-specific health checks (Table 3).

Table 3: 2023 Implementation Plan (IP) goal and national 2016/17 health check rates

Age	2023 IP goal health check rate (%)	2016/17 health check rate (%)
0–4	69	29
5–14	46	27
15–24	42	27
25–54	63	30
55 and over	74	41

Health checks: included in / excluded from the health check tool

This tool includes all health checks billed to the MBS regardless of which GPs or other health professionals provided them. This means that items billed to the MBS by mainstream GPs, as well as Aboriginal Community Controlled Health Services or other Indigenous health services, are included in the total numbers of health checks.

Conversely, anything not billed to the MBS is not counted. So even if a GP provides care similar to a health check, if it is not billed to the MBS, it is not included in this tool.

Health checks: not billed to the MBS

The number of health checks billed to Medicare does not give a complete picture of all health services provided to Indigenous people. Situations where care that is equivalent or similar to a MBS health check may be provided but is not billed as such include:

- where the care is provided by health care providers not eligible to bill Medicare (such as some health services provided by the Australian Royal Flying Doctor Service and by state and territory-funded services)
- where the care is provided by a MBS-billing service but for some reason is not billed—for example, if the patient does not have a valid Medicare number (as items cannot be billed without a Medicare number)
- where the care is billed as another MBS item, such as a standard consultation.

Health checks delivered by providers not eligible to bill Medicare are not recorded by Medicare, and therefore are not shown in this tool.

Some areas, especially in remote regions, may only have small numbers of MBS-billing GP services, and this limits the number of health checks billed to Medicare.

Indigenous Chronic Disease Package

The Indigenous Chronic Disease Package was an $805.5 million package funded by the Australian Government over 4 years from 2009 to 2013. It aimed to:

- tackle chronic disease risk factors
- improve the detection, management and follow-up of chronic diseases in primary health care
- expand the Aboriginal and Torres Strait Islander workforce and increase the capacity of the health workforce to deliver effective care (Table 3).

Table 4: Summary of Indigenous Chronic Disease Package measures

Priority Area	Key	Measure
Tackling chronic disease risk factors	**A1**	National action to reduce Indigenous smoking rates (subsequently merged with measure A2 to form the Regional Tackling Smoking and Healthy Lifestyle Team measures)
	A2	Helping Indigenous Australians reduce their risk of chronic disease (subsequently merged with measure A1 to form the Regional Tackling Smoking and Healthy Lifestyle Team measures)
	A3	Local Indigenous community campaigns to promote better health
Improving chronic disease management and follow-up care	**B1**	Subsidising PBS medicine co-payments
	B2	Higher utilisation costs for MBS and PBS
	B3	Supporting primary care providers to coordinate chronic disease management (subsequently split in to B3a: PIP Indigenous Health Incentive and B3b: CCSS program)
	B4	Improving Indigenous participation in health care through chronic disease self-management
	B5	Increasing access to specialist and multidisciplinary team care (subsequently split into measure B5a: Urban Specialist Outreach Assistance Program and measure B5b: Medical Specialist Outreach Assistance Program – Indigenous Chronic Disease)
	B6	Monitor and evaluate the Closing the Gap Chronic Disease Initiative

Workforce expansion and support	**C1**	Workforce support, education and training
	C2	Expanding the outreach and service capacity of Indigenous health organisations
	C3	Engaging Divisions of General Practice to improve Indigenous access to mainstream primary care (subsequently renamed as Improving Indigenous access to mainstream primary care program)
	C4	Attracting more people to work in Indigenous health
	C5	Clinical practice and decision support guidelines

Source: KPMG 2014.

Indigenous-specific health measures accessed via GPs

The main Indigenous-specific health measures which GPs provide directly, or provide access to, are:

- health checks (MBS item 715)
- follow-ups (MBS item 10987): provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner for or on behalf of a GP to a person who has had an MBS health check, whether an Indigenous-specific check (item 715) or a non-Indigenous-specific check.
- follow-ups (MBS items in the 81300 to 81360 range): provided by an Aboriginal and Torres Strait Islander health practitioner or allied health professional independent of a GP to a person who has had a MBS health check, whether an Indigenous-specific check (item 715) or a non-Indigenous-specific check.
- CtG co-payment prescriptions to reduce the cost of PBS medicines for eligible Indigenous people
- pneumococcal and influenza immunisations for Indigenous adults and other immunisations for Indigenous children in some states and areas
- listings on the Pharmaceutical Benefits Scheme (PBS) for Indigenous people
- care coordination and expedited access to follow-up services and a range of medical aids provided through the Integrated Team Care Program (previously the Care Coordination and Supplementary Services program)
- outreach health services provided by GPs, specialists, nurses and allied health professionals through the Medical Outreach – Indigenous Chronic Disease Program to increase access to services for Aboriginal and Torres Strait Islander people living in regional, rural and remote Australia.

Practices participating in the Practice Incentive Program Indigenous Health Incentive can also register eligible Aboriginal and Torres Strait Islander people for chronic disease management.

Medicare Benefits Schedule (MBS) statistics

The Medicare Benefits Schedule lists a range of medical services (consultations, procedures and tests) subsidised by the Australian Government, as well as the MBS rebate payable for each of these items.

The data presented in this tool about numbers of health checks are based on publicly available MBS reports.

The number of health checks in Report 1: national and state and territory data, July 2010–June 2017, is based on MBS data: Medicare Australia Statistics webpage (administered by the Department of Human Services).

The number of health checks in Report 2: Primary Health Network data, is based on MBS data by Primary Health Network (administered by the Department of Health).

MBS statistics are subject to periodic review by the Department of Human Services. The Medicare Australia Statistics webpage notes that the reports and tables it provides are for general information purposes only. It also notes that while Medicare Australia takes care in the compilation and provision of the information and data, it does not assume or accept any liability for the accuracy, quality, suitability and currency of the information or data, or for any reliance on the information or data.

Number of services where GPs work

Report 2: Primary Health Network data shows the number of services where general practitioners (GPs) work, as access to health checks requires access to GPs. This information was based on 2 sources:

- Details held by the Australasian Medical Publishing Company as at 2013. Services captured in those data include mainstream general practices, Aboriginal Community Controlled Health Services, and state and territory health clinics.
- Data from the Australian Royal Flying Doctor Service, which supplied the AIHW with information about community clinics in remote and very remote Aboriginal communities as at 2013.

The tool displays the number of services where GPs work at the Primary Health Network level. Services are included regardless of whether they are eligible to bill Medicare, so not all services counted are able to provide MBS item 715 health checks. Information on the number of GPs at each service is not available.

Population estimates: Report 1

The Indigenous population estimates and projections, Series B projections produced by the Australian Bureau of Statistics (ABS), based on 2011 Census counts, do not include data for sex disaggregation in the 65 and over age group in 2010 and 2011 for the

Australian Capital Territory (ACT) and Tasmania. The following estimation methods were used to estimate the Indigenous population for these 2 unpublished data points.

For the ACT, the male/female 65 and over age group Indigenous population was estimated by multiplying the national Indigenous people gender proportion of 65 and over by the total ACT Indigenous population aged 65 and over.

For Tasmania, the male/female 65 and over age group Indigenous population was estimated by multiplying the gender proportion of Indigenous people in the 60–64 age group in Tasmania by the total Tasmanian Indigenous population aged 65 and over.

Population estimates for the time periods shown in Report 1 are:

- Calendar year population = mid-year population as at 30 June each year from ABS population data
- Quarter population = calendar year population divided by 4
- Financial year population = sum of relevant 4 quarters

Population estimates: Report 2

While the ABS produces Indigenous population estimates at the national and jurisdictional level, it does not routinely produce Indigenous population information for Primary Health Networks. But population estimates at SA2 levels were developed by Prometheus Information Pty Ltd under contract by the Department of Health (PHIDU 2015). The AIHW applied Department of Health-issued concordances from SA2 level to Primary Health Network level to the estimates developed by Prometheus to produce population estimates for Primary Health Networks for each financial year shown in Report 2.

Primary Health Networks

The Australian Government established 31 Primary Health Networks as of 1 July 2015, with the aim of improving patient outcomes by working with GPs, other primary care providers, secondary care providers and hospitals. Information on the location of Primary Health Networks, as well as boundary and concordance files, can be found at the Department of Health website. Primary Health Network boundaries are aligned to Local Hospital Networks to facilitate working relationships with public and private hospitals.

Provider versus patient address data allocation

The address of the doctor who provides the health check (the provider) is used to allocate health check data to different Primary Health Networks, whereas the address of the patient who receives the health check is used to allocate data to different states and territories. So, for example, if a patient lives in Queensland but gets a health check in New South Wales, the health check will be counted in the Queensland totals for state and territory reports, but counted in the New South Wales totals for Primary Health Network reports. This means for Tasmania, the Australian Capital Territory and the

Northern Territory (that is, states and territories that are a single Primary Health Network), the number of health checks may be different depending on whether the information is viewed in a state and territory report, or a Primary Health Network report.

Quarters

In this tool, quarters (Q) refer to:

Q1—1 January to 31 March

Q2—1 April to 30 June

Q3—1 July to 30 September

Q4—1 October to 31 December.

Reporting periods

The reporting period covered by Report 1: national and state and territory data, is July 2010–June 2017. This is because July 2010 was the start of the first full quarter for which data were available after the 3 separate age-based Indigenous health check MBS item numbers were combined to a single item number (715) (see Timeline of major developments in health checks (PDF 106kB)).

The reporting period covered by Report 2: Primary Health Network data, is July 2012–June 2016. This is because only these 4 years of data have been made available.

States and territories: order

In this tool, states and territories are listed in order of the size of their Indigenous populations, from largest to smallest: New South Wales, Queensland, Western Australia, Northern Territory, Victoria, South Australia, Tasmania and the Australian Capital Territory.

Timeline of major developments in health check implementation

The Timeline of major developments in health checks (PDF 106kB) shows the increase in uptake from the date of implementation and highlights relevant major developments (Table 5).

Table 5: Major developments

When?	What?	Why?
November 1999	55 years & over annual health check (MBS item	The first Indigenous-specific health check established as the Indigenous equivalent of health checks for non-Indigenous people aged 75 years and over

	704) introduced	
May 2004	15–54 years 2-yearly adult health check (MBS item 710) introduced	The extension of health checks to adults recognised that the conditions responsible for early deaths of Aboriginal and Torres Strait Islander people started before the age of 55.
May 2006	0–14 years annual child health check (MBS item 708) introduced	With this addition, Aboriginal and Torres Strait Islander people of all ages were eligible for preventive health checks.
December 2008	National Partnership Agreement implemented	The National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes included the Indigenous Chronic Disease Package. This package was funded by the Australian Government over 4 years from 2009–2013 and included a number of elements relevant to improving uptake of Indigenous-specific health measures.
July 2009	Medicare Local Closing the Gap workforce established	Part of the Indigenous Chronic Disease Package, this workforce comprised: 86 full-time equivalent Indigenous outreach workers to support Aboriginal and Torres Strait Islander people access primary health-care services and follow-ups 86 full-time equivalent Indigenous health project officers to lead Aboriginal and Torres Strait Islander health issues within Medicare Locals, and raise awareness of Closing the Gap initiatives relevant to mainstream primary care. This workforce assisted with the delivery of the Care Coordination and Supplementary Services and Improving Indigenous Access to Mainstream Primary Care programs.
March 2010	Indigenous Health	Part of the Indigenous Chronic Disease Package, the Indigenous Health Incentive was included under the Practice Incentives Program.

	Incentive introduced	
May 2010	Health check items 704, 708 and 710 combined	The 3 separate item numbers were replaced by a single item: MBS item 715. The frequency of health checks was standardised to annual, so Aboriginal and Torres Strait Islander people aged 15–54 were able to have a health check every year, instead of every 2 years.
2010	Indigenous status required by Royal Australian College of General Practitioners Standards	Existing requirements were strengthened, so practices seeking accreditation had to demonstrate they were routinely recording Aboriginal and Torres Strait Islander status in their active patient records.
July 2011–12	Divisions of General Practice transitioned to Medicare Locals	Divisions of General Practice (n = 112), as well as their national and jurisdiction level support structures (the Australian General Practice Network and 8 state-based organisations) were replaced with Medicare Locals (n= 62), as part of the National Health Reform Agenda.
June 2014	Australian Medicare Local Alliance abolished	Australian Medicare Local Alliance (the national coordination body for Medicare Locals) was abolished. Regional coordination and support of the Closing the Gap workforce undertaken by the Alliance also ceased.
July 2015	Medicare Locals replaced by Primary Health Networks	Medicare Locals (n= 62) were replaced by Primary Health Networks (n = 31). In 2015–16, funding for the Care Coordination and Supplementary Services and Improving Indigenous Access to Mainstream Primary Care programs was provided through Primary Health Networks.
July 2016.	Integrated Team Care Activity started	Care Coordination and Supplementary Services and Improving Indigenous Access to Mainstream Primary Care program funding was combined into new Integrated Team Care Activity.

Usage rates

Report 1: national and state and territory data, shows usage rates of MBS item 715 health checks as follows:

- quarterly usage rate: the number of checks in the quarter divided by the estimated quarterly population, expressed as a percentage
- annual usage rate: the number of checks in the financial or calendar year divided by the estimated annual Indigenous population, expressed as a percentage.

Report 2: Primary Health Network data, shows usage rates only for financial years.

Updates to tool

Date	Features
3 April 2014	Tool first released. Included Medicare Local information from 1 July 2011 to 30 June 2013. Source of Medicare Local Indigenous population data was preliminary estimates developed by the Public Health Information Development Unit, University of Adelaide.
20 August 2014	Information at the national, jurisdiction and peer group level added. Source of Medicare Local Indigenous population data changed to ABS 2011 estimated resident population (ERP). Other Indigenous population data sources were 2011 ERP and projections to 2014. MBS data from 1 July 2010 to 31 March 2014 (national and jurisdiction) accessed from Medicare Australia Statistics web page on 4 June 2014. MBS data from 1 July 2013 to 31 March 2014 (Medicare Locals and peer groups) accessed from Medicare Australia Statistics webpage on 6 June 2014.
3 December 2014	MBS data from 1 April 2014 to 30 June 2014 (national and jurisdiction) accessed from Medicare Australia Statistics web page on 4 September 2014. MBS data from 1 April 2014 to 30 June 2014 (Medical Locals and peer groups) accessed from Medicare Australia Statistics web page on 12 September 2014.
28 July 2015	MBS data from 1 July 2014 to 31 December 2014 (Medical Locals, peer groups, jurisdiction and national reports) accessed from Medicare Australia Statistics webpage on 2 March 2014.

	Primary Health Networks, numbers of services where GPs work and calendar year data added.
21 July 2016	Increased age disaggregation to 10 age groups for national and state and territory data. Reported health check data for Australia and states and territories by calendar years, financial years and quarters up to 31 December 2015. Medicare Local and Primary Health Network level data are reported up to 31 December 2014.
6 December 2017	Showed data on number of health checks for Australia and states and territories by calendar years, financial years and quarters up to December 2016/June 2017. Showed data on number of people receiving health checks for Australia and states and territories by financial years from July 2012 to 30 June 2015. Deleted reports for Medicare Locals and peer groups

Acknowledgments

AIHW authors and contributors

This tool was originally designed and authored by Helen Kehoe, Ronda Ramsay and Helen Johnstone from the Indigenous and Children's Group at the Australian Institute of Health and Welfare. This team was responsible for the first (April 2014) and second (August 2014) releases, with assistance from Jeremy Spindler on the second release.

The third (December 2014) release was authored by Helen Kehoe, Jeremy Spindler and Michelle Gourley.

The fourth (July 2015) release was authored by Helen Kehoe, Jeremy Spindler and Adriana Vanden Heuvel. Valuable assistance was provided by Martin Edvardsson, Jessica Cargill and Brett Nebe.

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The sixth (December 2017) release was authored by Helen Kehoe, Scott Wu and Stacey Costello, under the management of Indrani Pieris-Caldwell and Helen Johnstone. Quan Nguyen and Kate Wright provided valuable assistance.

Fadwa Al-Yaman, Head of the Indigenous and Children's Group at AIHW, provides ongoing advice and guidance on this project.

Stacey Costello, from AIHW's Technology and Transformation Unit, built the original reports in the SAS VA software. He continues to help refine, improve and maintain the tool.

External contributors

Dr Mitchell Whitelaw, Associate Professor Faculty of Arts and Design at the University of Canberra, produced the first prototype of the tool and helped change thoughts into reality.

Prometheus Information Pty Ltd produced Indigenous population estimates at small geographic levels, under contract to the Department of Health. Population estimates at the Medicare Local, peer group and Primary Health Network levels used in the tool were based on, or sourced from, this work.

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- Australian Medicare Locals Alliance and individual Medicare Locals
- National Aboriginal Community Controlled Health Organisation and members
- Royal Australian College of General Practice
- the Australian Bureau of Statistics
- the Australian Government Departments of Health, Human Services, and Prime Minister and Cabinet
- advisory bodies including the National Advisory Group on Aboriginal and Torres Strait Islander Information and Data and the National Aboriginal and Torres Strait Islander Health Standing Committee
- Inala Indigenous Health Service
- Indigenous Eye Health Unit, Melbourne School of Population and Global Health, Centre for Health Equity, The University of Melbourne
- National Centre for Immunisation Research and Surveillance.

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Notes

What's new in release 6, 6 December 2017

- For the national, state and territory report, adds data on the number of health checks billed to Medicare up to June 2017
- For the Primary Health Network report, includes updated data from July 2012 to June 2016
- Removes reports for Medicare Locals and peer groups.

Related material

Resources

- Aboriginal and Torres Strait Islander Health Performance Framework
- Tracking progress against the Implementation Plan goals for the Aboriginal and Torres Strait Islander Health Plan 2013–2023